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**In the Supreme Court of the United States**

OCTOBER TERM, 1998

**TOMMY OLMSTEAD, COMMISSIONER OF THE  
DEPARTMENT OF HUMAN RESOURCES OF THE STATE OF  
GEORGIA, ET AL.,**  
*Petitioner,*

v.

**L.C. AND E.W., EACH BY JONATHAN ZIMRING,  
AS GUARDIAN AD LITEM AND NEXT FRIEND,**  
*Respondents.*

**ON WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT**

**AMICUS CURIAE BRIEF OF 58 FORMER STATE  
COMMISSIONERS AND DIRECTORS OF  
MENTAL HEALTH AND DEVELOPMENTAL  
DISABILITIES, ET AL. IN SUPPORT OF  
RESPONDENTS**

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## TABLE OF CONTENTS

INTEREST OF <i>AMICI CURIAE</i> .....	1
SUMMARY OF ARGUMENT .....	2
ARGUMENT .....	4
I. COMMUNITY INTEGRATION DOES NOT IMPOSE UNREASONABLE BURDENS ON THE STATES.....	4
A. Community Integration Will Not Result in Improper or Careless Deinstitutionalization. ....	4
B. States Already Provide Most Disability Services in the Community.....	6
C. Federal Funding is Available to Assist States in Paying for Community Care. ....	9
D. Community Care Costs Less than Institutionalization.....	13
II. RESISTANCE TO COMMUNITY INTEGRATION IS THE RESULT OF HISTORIC DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES, WHICH IS PRECISELY THE SOCIAL ILL THE ADA AND THE INTEGRATION MANDATE WERE MEANT TO CORRECT. ....	21
CONCLUSION .....	27
APPENDIX .....	ia

## TABLE OF AUTHORITIES

	Page(s)
<u>Alabama Nursing Home Ass'n v. Harris</u> , 617 F.2d 388 (5 <sup>th</sup> Cir. 1980).....	12
<u>Cable v. Dept. of Developmental Services of the State of Calif.</u> , 973 F. Supp. 937 (C.D. Cal. 1997) .....	5
<u>Charles Q. v. Houston</u> , 1997 U.S. Dist. Lexis 17305 (M.D. Pa. 1997).....	5
<u>City of Cleburne v. Cleburne Living Center</u> , 473 U.S. 432 (1985) .....	21, 24
<u>Concerned Parents to Save Dreher Park Center v. City of West Palm Beach</u> , 846 F. Supp. 986 (S.D. Fla. 1994).....	12
<u>Helen L. v. DiDario</u> , 46 F.3d 325 (3 <sup>rd</sup> Cir.), cert. denied, 516 U.S. 813 (1995).....	17, 26
<u>Int'l Union, United Automobile Workers of America v. Johnson Controls, Inc.</u> , 499 U.S. 187 (1991) .....	13
<u>Kathleen S. v. Dept. of Public Welfare</u> , 10 F. Supp.2d 476 (E.D. Pa. 1998).....	5
<u>Kroll v. St. Charles County, Missouri</u> , 766 F. Supp. 744 (E.D. Mo. 1991) .....	13
<u>L.C. v. Olmstead</u> , 138 F.3d 893 (11 <sup>th</sup> Cir. 1998) .....	5, 6, 12
<u>L.C. v. Olmstead</u> , 1997 WL 148674 (N.D. Ga., March 26, 1997) .....	17

<u>Williams v. Wasserman</u> , 937 F. Supp. 524 (D. Md. 1996).....	5
<b>Statutes, Rules and Regulations</b>	
42 U.S.C. §§ 300x <u>et seq.</u> .....	12
42 U.S.C. § 1396d(a)(12) .....	11
42 U.S.C. § 1396d(a)(13) .....	11
42 U.S.C. § 1396d(a)(14) .....	11
42 U.S.C. § 1396d(a)(15) .....	10
42 U.S.C. § 1396d(a)(19) .....	11
42 U.S.C. § 1396d(a)(B) .....	11
42 U.S.C. § 1396d(d).....	10
42 U.S.C. § 1396n(b).....	11
42 U.S.C. § 1396n(c).....	15
42 U.S.C. § 1396n(c)(1) .....	10
42 U.S.C. § 1396n(g).....	11
42 U.S.C. §§ 8011-8013 .....	12
42 U.S.C. § 12101(a)(2) .....	21
42 U.S.C. § 12101(b)(1).....	21
GA. CODE ANN. § 37-3-64.....	19



GA. CODE ANN. § 37-3-91.....	19
HAW. REV. STAT. § 333F-6.....	19
35 C.F.R. Pt. 35, App. A, 35.130.....	2
42 C.F.R. 440.90.....	11
42 C.F.R. 440.130.....	11
42 C.F.R. 440.150.....	10
42 C.F.R. 440.167.....	11
44 C.F.R. 441.300.....	10

#### Other Authorities

135 CONG. REC. S4986 (daily ed., May 9, 1989).....	12, 18
135 CONG. REC. S10,798 (daily ed., Sept. 7, 1989).....	18
136 CONG. REC. H2603 (daily ed., May 22, 1990).....	25
H.R. REP. NO. 101-485 (III) at 49-50 (1990), reprinted in 1990 U.S.C.C.A.N. 472-73.....	12

<i>Americans with Disabilities Act: Hearing Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped, 101<sup>st</sup> Cong. 66 (1989).....</i>	18
---	----

<i>Joint Hearing on Recommendations to Improve Services for Mentally Retarded Citizens before the Sub- committee on the Handicapped of the Senate Committee on Labor and Human Resources and the Subcommittee on Labor, Health and Human</i>	
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<i>Services, Education, and Related Agencies of the Senate Committee on Appropriations, 98<sup>th</sup> Cong. 48 (1984).....</i>	18
--	----

AFSCME PUBLIC POLICY DEPARTMENT, AFSCME AND THE MENTALLY DISABLED: INSTITUTIONS TO COMMUNITY CARE (June 1992).....	25
--	----

Herbert Bengelsdorf, et al., <i>The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service</i> , 181 J. NERVOUS & MENTAL DISEASE 757 (1993).....	14
---	----

<i>Finding a Place for the Mentally Ill</i> , BOSTON GLOBE, Jan. 31, 1996, at 12.....	24
--	----

DAVID BRADDOCK, THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES (David Braddock, et al. eds., 5 <sup>th</sup> ed. 1998).....	6,7,8,9,10,14, 19,20,22,23
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---	----

Marianne Comfort, <i>Disabled Neighbors Joining in Daily Life</i> , Akron Beacon Journal, Feb. 2, 1997, at G3.....	24
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CONGRESSIONAL RESEARCH SERVICE, SUBCOMMITTEE ON HEALTH AND ENVIRONMENT OF THE COMMITTEE ON	
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ENERGY AND COMMERCE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (Jan. 1993) .....	2
Timothy M. Cook, <i>The Americans with Disabilities Act: The Move to Integration</i> , 64 TEMP. L. REV. 393 (Summer 1991).....	14,18,19,23,25
DEVELOPMENTAL DISABILITIES ADMINISTRATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OPERATING BUDGET ANALYSIS (Feb. 8, 1995) .....	16
Laird W. Heal, <i>Institutions Cost More Than Community Services</i> , AMERICAN JOURNAL OF MENTAL DEFICIENCY 121 (1987).....	17
GOVERNOR'S SPECIAL COMMISSION ON CONSOLIDATION OF HEALTH AND HUMAN SERVICES INSTITUTIONAL FACILITIES, ACTIONS FOR QUALITY CARE (JUNE 1991) .....	16
<i>State to Close New Castle Center</i> , THE INDIANAPOLIS STAR, July 24, 1997, at B1 .....	20
K. Charlie Lakin and Robert Prouty, <i>Trends in Institution Closure</i> , IMPACT, University of Minnesota, Winter 1995-96.....	7,14,19,20
Sheryl A. Larson and K. Charlie Lakin, <i>Deinstitutionalization of Persons with Mental Retarda- tion: The Impact on Daily Living</i> , JOURNAL OF ASSOCIATION OF PERSONS WITH SEVERE HANDICAPS 324 (March 1989) .....	22
Elizabeth C. McDonel, et al., <i>Downsizing State Operated Psychiatric Facilities: Three New Research Efforts to Examine the Quality of Community Care for Persons with Severe Mental</i>	

<i>Illness</i> (National Association of State Mental Health Program Directors Research Institute, Fourth Annual National Conference Proceedings, Jan. 1994) .....	23
STATE OF OREGON, DEVELOPMENTAL DISABILITY HCB WAIVER APPLICATION, FY 1999-2004 (Oct. 1998).....	15
PLANNING ADVISORY COMMITTEE TO THE OFFICE OF MENTAL RETARDATION, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, A MULTI-YEAR PLAN FOR PENNSYLVANIA'S MENTAL RETARDATION SERVICE SYSTEM (July 1997) .....	16, 19
Opening Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation and Hospitals, before U.S. Commission on Civil Rights, November 13, 1998 .....	7, 23, 24
REINVESTMENT OF RESOURCES FROM FACILITY DOWNSIZING/CLOSURES TO COMMUNITY SERVICES: A COMPREHENSIVE REVIEW OF REINVESTMENT INITIATIVES (February 2, 1999) .....	7, 9, 14
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John Richardson, <i>A Struggle to Fit In</i> , MAINE SUNDAY TELEGRAM, Dec. 1, 1996, at 1A .....	24
Aileen B. Rothbard, et al., <i>Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up Study</i> ,	

AMERICAN JOURNAL OF PSYCHIATRY, December 9, 1998 .....	13
Aileen B. Rothbard, et al., <i>Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story</i> , 24 ADMINISTRATION AND POLICY IN MENTAL HEALTH 391 (May 1991).....	9
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Gary A. Smith, et. al., <i>The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"</i> MENTAL RETARDATION 262 (August 1996).....	10, 11
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Gary A. Smith and Robert M. Gettings, THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY (October 1994) .....	10,11,13,15
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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH, UNITED STATES, 1996 (Ronald W. Manderscheid and Mary Anne Sonnenschein, eds., 1996) .....	8, 9, 25
Web Site of the National Association of State Mental Health Program Directors (last modified Feb. 17, 1999), < <a href="http://www.nasmhpd.org">http://www.nasmhpd.org</a> > .....	7, 8

## INTEREST OF AMICI CURIAE<sup>1</sup>

This case raises issues of great importance to the mental health and disability communities in this country. As former state commissioners and directors of mental health and developmental disabilities and the state of Oregon, *amici* are uniquely positioned to speak to many of the policy issues presented by this case, including how public systems of care may operate in a manner that best addresses the needs of people with disabilities and that is cost-effective for the primary providers of care, the fifty states. As a result of their considerable experience not only in serving people with disabilities directly but also in managing state systems of care, *amici* have a breadth of understanding about the broader social implications of this case, such as the mechanisms states use to fund disability services and the long and tortured history that lies behind the states' treatment of people with mental disabilities.

*Amici* are from thirty-six different states: Alabama, Alaska, Arizona, California, Connecticut, Colorado, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Washington, Wyoming, and the District of Columbia. Among the *amici* on whose behalf this brief is filed are a former directors of mental health and mental retardation from the state of Georgia and former commissioners or directors from several states that have joined the *amicus* brief on behalf of the petitioners, including Colorado, Hawaii, Indiana, Louisiana, Mississippi, South Carolina, Tennessee, Texas, and Wyoming.<sup>2</sup> These former state commissioners and directors of developmental disability and/or mental health have been involved with every aspect

<sup>1</sup> The parties have consented to the filing of this brief under S. Ct. Rule 37.2 and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S. Ct. Rule 37.6, *amici* state that counsel for a party did not author this brief in whole or in part and that no one other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief.

<sup>2</sup> Biographies of the 58 former commissioners and directors on whose behalf this brief is filed are attached to the brief as Appendix A.



of their respective state service systems, from making budgetary decisions to overseeing the closing of institutions and the development of new community care alternatives, to tackling challenges posed by local community groups and unions. *Amici* strongly support community services in integrated settings as the best method of treating the majority of people with disabilities.<sup>3</sup> *Amici* believe that the Court of Appeals' decision should be affirmed and that enforcement of the Attorney General's integration regulation will not impose unreasonable financial or administrative burdens on the states. In fact, the position of *amici* is that, in situations in which mental health professionals recommend that individuals receive treatment in the community, such treatment is more appropriate, more effective, and less costly for the states.

### SUMMARY OF ARGUMENT

The Eleventh Circuit's decision to enforce the Attorney General's integration regulation will not profoundly change the way states are providing care to their citizens with disabilities.<sup>4</sup> Instead, it will result in more cost-effective and better quality systems of care. The Americans with Disabilities Act ("ADA") prohibits as discriminatory the unnecessary segregation of individuals with disabilities in institutions when, as here, their treating profes-

<sup>3</sup> Essentially, the term "integrated setting" means a community setting, as opposed to an institutional setting. See 35 C.F.R. Pt. 35, App. A, § 35.130 (ADA regulations define an integrated setting as one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible"). This term is well understood in the mental health and developmental disability fields. Community treatment in an integrated setting generally includes residential services like a group or family home, treatment and habilitation services such as assistance with acquiring, retaining and improving daily living, socialization and adaptive skills, and support services like home health aides, self-help groups and family supports. See CONGRESSIONAL RESEARCH SERVICE, SUBCOMMITTEE ON HEALTH AND ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 387 (Jan. 1993).

<sup>4</sup> Throughout this brief, the term "with disabilities" refers to both people with developmental disabilities and people with psychiatric disabilities. Where further distinction between the two groups is necessary, such distinction will be made in the text.

sionals have concluded that they may be appropriately served in the community. In 1990, when Congress enacted the ADA, it was well established that providing care to qualified individuals with disabilities in community settings, as required by the integration regulation, would actually save the states money and result in better quality care.

The fact that the states have traditionally provided services to people with disabilities by confining them in large institutions does not make the integration mandate less compelling. The obligation to provide services to qualified individuals with disabilities in the community rather than in institutions will not significantly change the states' disability systems, both because institutions will remain a viable option when needed and, more importantly, because states already provide most of their disability services in the community. Furthermore, because the federal government provides substantial funding to assist states with the cost of community-based treatment and because institutional care is so much more costly than community care, the integration regulation will not impose unreasonable financial burdens on the states.

The ADA was enacted to rectify a long history of discrimination suffered by people with disabilities in this country. However, stereotypes about people with disabilities and local political and economic interests continue to influence how states treat these citizens. Unfortunately, such arbitrary factors, unrelated to issues of treatment or expense, have caused many states to resist the move to more community-based care, even where medically appropriate and economically sound. Because Congress intended the ADA to be a bulwark against disability discrimination, this Court should enforce that mandate by affirming the decision of the Court of Appeals.



## ARGUMENT

### I. COMMUNITY INTEGRATION DOES NOT IMPOSE UNREASONABLE BURDENS ON THE STATES.

Contrary to the alarmist claims of the petitioners and the *amici* states, enforcement and implementation of the Attorney General's integration regulation will not result in careless deinstitutionalization or impose unreasonable financial burdens on the states. Rather, the majority of states already use integrated settings to care for their citizens with disabilities and currently provide most of their disability services in the community. Moreover, there is substantial evidence that community-based care is less costly than institutional care, and in any event, federal funding is available to help the states defray costs that might be associated with moving qualified individuals to community care. In short, if this Court affirms the decision of the Court of Appeals, it will not substantially disrupt state mental health and developmental disability systems. Rather, the experience of the *amici*, the professional literature and studies in the field strongly suggest that it will improve the quality of care states provide and result in a more cost-effective method of delivering services to people with disabilities.

#### A. Community Integration Will Not Result in Improper or Careless Deinstitutionalization.

This case is not about "deinstitutionalization" in the sense of widespread closure of institutions and release of all patients into the community, whether qualified or not, with or without appropriate care. If this Court affirms the Eleventh Circuit's decision, it will not result in vast numbers of individuals with disabilities roaming the streets of the nation's cities, without sufficient care, treatment or residential placement. Although the petitioners and the *amici* states who support them here seek to portray the case this way, as part of a parade of horrors that will allegedly follow

if the Eleventh Circuit's decision is affirmed,<sup>5</sup> the ADA does not require states to undertake "massive deinstitutionalization," see *L.C. v. Olmstead*, 138 F.3d 893, 901 (11<sup>th</sup> Cir. 1998), and neither the respondents nor the *amici* urge such a result.

Instead, the respondents and *amici* maintain that, in the context of this case, enforcing the Attorney General's integration regulation simply requires that states provide community services *to institutionalized individuals who are deemed qualified for and appropriate to receive such services by their treating professionals*. The argument of the respondents, already adopted by both the district court and the Eleventh Circuit, as well as by other federal courts to have considered this issue, see, e.g., *Cable v. Dept. of Developmental Services of the State of Calif.*, 937 F. Supp. 937 (C.D. Cal. 1997); *Charles Q. v. Houston*, 1997 U.S. Dist. Lexis 17305 (M.D. Pa. 1997); *Kathleen S. v. Dept. of Public Welfare*, 10 F. Supp.2d 476 (E.D. Pa. 1998); *Williams v. Wasserman*, 937 F. Supp. 524 (D. Md. 1996), is that keeping an individual in an institution once a treating professional has determined that the individual could be treated in an integrated setting constitutes unnecessary segregation in violation of the ADA. The Court of Appeals explicitly adopted this position:

[O]ur holding does not mandate the deinstitutionalization of individuals with disabilities. Instead we hold that where, as here, a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting – the most integrated setting appropriate to that patient's needs. Where there is no such finding, on the other hand, nothing in the

<sup>5</sup> See, e.g., Brief for Petitioners at 2 ("This is not the first national effort to impose a one-size-fits-all solution to an intricate medical problem – here, institutionalization versus deinstitutionalization of medical care."); *Amicus Curiae* Brief of the States in Support of Petitioners ("States' Brief") at 2 ("The overall thrust of this litigation is toward massive deinstitutionalization, regardless of the disruption and regardless of the short-term costs.") and at 4 (characterizing the respondents' argument as requiring "an immediate transition...to a community setting for each and every individual for whom it [is] a theoretical possibility").

ADA requires the deinstitutionalization of that patient.

*L.C.*, 138 F.3d at 901. In light of the clear language of the Court of Appeals, *amici* vigorously dispute the apocalyptic claims of the *amicus* states that enforcing the integration regulation will result in the careless release of large numbers of individuals with disabilities into the community without proper care and support. States' Brief at 4.<sup>6</sup>

### B. States Already Provide Most Disability Services in the Community.

More importantly, states are already moving in the direction of using community services as the primary means of treating their citizens with disabilities, and they are experiencing great success with those programs. Therefore, the claim in the States' Brief that placement of qualified individuals in these existing programs would significantly change the states' disability systems is inaccurate. The statutes of many states, including Georgia and several of the *amicus* states, explicitly provide that qualified individuals with disabilities be placed in the community or in the least restrictive setting appropriate to their needs. *See* Brief of *Amicus Curiae* American Association on Mental Retardation, et. al. Therefore, the petitioners and the *amicus* states cannot complain that this Court's affirmance of the Eleventh Circuit's decision would impose unreasonable burdens on them when the integration regulation simply confirms a policy that many of the states' legislatures have explicitly enacted.

Furthermore, the clear trend throughout the country in the fields of developmental disability and mental health care is toward downsizing or closing institutions and providing care in integrated settings. For example, at least six states (Alaska, New Hampshire, New Mexico, Rhode Island, Vermont, West Virginia) and the Dis-

<sup>6</sup> As discussed further below, providing community care to qualified individuals with disabilities need not result in the complete elimination of state-run institutions. It will remain economically feasible for states to make institutions available for those individuals who need and choose such care.

trict of Columbia now provide *all* services to people with mental retardation in the community. *See* DAVID BRADDOCK, *THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES* (David Braddock, et al. eds., 5<sup>th</sup> ed. 1998) at 9 ("Braddock"). Since the late 1980s, states have closed or reduced in size more institutions than at any other time in history. Between 1988 and 1995, states closed more than 85 institutions for people with developmental disabilities, over three and one-half times more closures than in the previous twelve years. *See* K. Charlie Lakin and Robert Prouty, *Trends in Institution Closure*, IMPACT, University of Minnesota, Winter 1995-96 at 4 ("Lakin and Prouty").

There is an equally strong trend toward serving more individuals with mental illnesses in the community, although somewhat fewer state-run psychiatric institutions have been closed. According to a survey of state mental health commissioners, "76% of the States are currently working to reorganize their State Psychiatric Hospital systems. The most common activities are downsizing existing hospitals, closing wards, reorganizing or reconfiguring one or more hospitals, [and] closing State hospitals." Web Site of the National Association of State Mental Health Program Directors (last modified Feb. 17, 1999), <<http://www.nasmhpd.org>> ("NASMHPD Web Site"). *See also* REINVESTMENT OF RESOURCES FROM FACILITY DOWNSIZING/CLOSURES TO COMMUNITY SERVICES: A COMPREHENSIVE REVIEW OF REINVESTMENT INITIATIVES (February 2, 1999) at 3 ("REINVESTMENT OF RESOURCES")(most state mental health authorities are actively reducing the size of state hospitals through either closure or downsizing). During the 1990s, states closed 37 state psychiatric hospitals, three times more closures than in the previous two decades combined. Opening Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation and Hospitals, before U.S. Commission on Civil Rights, November 13, 1998, at 1-2 ("Power Statement"). Among the states actively downsizing state psychiatric hospitals are Georgia and several of the *amicus* states (Louisiana, South Carolina, and Wyoming). *See* Joint Appendix at 201; NASMHPD Web Site.

In addition to closing or downsizing institutions, states currently serve a greater number of individuals with disabilities in the



community than at any time in the past. The total number of people with developmental disabilities served in the community in the United States grew from fewer than 5000 in 1960 to more than 250,000 in 1996, while the institutional population decreased by more than 130,000 in the same period. Braddock at 26. In addition, all but two states reduced the number of individuals with developmental disabilities in institutions between 1992 and 1996. *Id.* Likewise, from 1970 to 1990, the number of beds available in state psychiatric hospitals decreased by nearly 50%. The state hospital population decreased from 186 residents per 100,000 in 1969 to 33 residents per 100,000 in 1992. See NASMHPD Web Site; Aileen B. Rothbard and Eri Kuno, *The Success of Deinstitutionalization: Empirical Findings from Case Studies on State Hospital Closures*, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY, January 28, 1999 at 1.

The shift of dollars away from institutions and to community services further demonstrates the states' current commitment to community-based care. From 1992 to 1996, state spending for community services for individuals with developmental disabilities increased at an inflation-adjusted rate of 41%, or 9% per year. This compares to a 7% decline in institutional spending for developmental disabilities. By 1989, the amount of state money spent on community care exceeded the amount of funds allocated for institutions. See Braddock at 32. The same is true for mental health spending. In 1981, 63% of state mental health dollars were spent on institutional care. By 1993, expenditures for community-based services exceeded institutional expenditures. See NASMHPD Web Site (in 1993, states spent \$6.92 billion on community care, as compared to \$6.89 billion on institutional care). Between 1981 and 1993, state psychiatric hospital spending decreased by 24.5% and spending on community services increased by 44.1%. *Id.* See also UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH, UNITED STATES, 1996 (Ronald W. Manderscheid and Mary Anne Sonnenschein, eds., 1996) at 100 (the proportionate share of total state mental health expenditures for institutions changed significantly from 1969 to 1992; in 1969, spending on state-run hospitals represented 55% of total state mental health expenditures, as compared to 27% in 1992). The trend in Georgia is consistent with the national trend.

In recent years, the state has redirected dollars from developmental disability institutions to community services to the point where 57% of state funding went toward community services in 1997. Joint Appendix at 200-01.

### C. Federal Funding is Available to Assist States in Paying for Community Care.

Because the funding for community-based services does not come from the states alone, full implementation of the Attorney General's integration regulation will not create economic hardship for the states. The federal government has long provided a portion of state funding for mental health and developmental disability services, and the percentage of federal funding has increased substantially with the move to community-based care. See REINVESTMENT OF RESOURCES at 10 ("[m]any studies have noted the shifting of mental health care costs to the [f]ederal government through Medicare and Medicaid"); Braddock at 33 (in 1996, federal funding represented over 43% of all funding for community-based services for people with developmental disabilities); Mental Health, United States, 1996 at 102 (in 1992, federal funding represented 31% of all spending for treatment of the mentally ill, compared to 40% from state funds). The structure of federal funding programs now clearly favors community treatment. See Braddock at 34 (citing the federal Medicaid Home and Community-Based Services waiver program as a central reason federal funding for developmental disability community services increased by more than 18% per year throughout the 1980s); Mental Health, United States, 1996 at 103 (federal legislation promotes community-based services to the exclusion of state hospital services); Aileen B. Rothbard, et al., *Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story*, 24 ADMINISTRATION AND POLICY IN MENTAL HEALTH 391, 396 (May 1991) (providing services in the community to individuals previously institutionalized at Philadelphia State Hospital created a 300% increase in federal participation in the care of those individuals because of structure of federal funding programs). By allowing states greater flexibility in how they can use federal funds to pay for mental health and developmental disability care and creating programs that are targeted toward community-based services,



the federal government has substantially eased the economic burden of providing care to people with disabilities.

The most important funding mechanism for community care for people with developmental disabilities is the Home and Community-Based Services ("HCBS") waiver program under the Medicaid program, in which all fifty states participate. *See* Braddock at 10. This program allows states to use Medicaid money to provide services in the community to individuals with developmental disabilities who would otherwise be treated at a higher cost in institutional settings. *See* 42 U.S.C. § 1396n(c)(1); 44 C.F.R. § 441.300 (the waiver program "permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization"). The HCBS waiver program has enabled states to move institutionalized individuals to less expensive community-based settings.<sup>7</sup>

States have used the HCBS waiver program to move countless individuals with developmental disabilities out of institutions. Indeed, the waiver program is no longer an alternative to institutionalization, it is now the primary means of serving people with developmental disabilities. *See* GARY A. SMITH AND ROBERT M. GETTINGS, *THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY* 14-15 (October 1994); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262 (August 1996) (since 1992, the number of in-

<sup>7</sup> Under the Medicaid program, nearly all state institutions for people with developmental disabilities are categorized as "intermediate care facilities for individuals with mental retardation" (ICF/MRs). *See* 42 U.S.C. §§ 1396d(a)(15), 1396d(d); 42 C.F.R. § 440.150. Under Medicaid, the cost of these facilities is shared by the federal government and the states according to a statutory formula. The formula produces, for each state, the specific percentage of the cost that the state will pay and the "federal match," the specific percentage that the federal government will pay. The federal match generally covers from 50 to 75 percent of the cost of ICF/MR services, and state funding is used to finance the remainder of the costs. The federal match is the same for both HCBS waiver services and ICF/MR services.

dividuals served by HCBS waiver programs has been increasing at an annual rate of 29.2%, while the number of individuals served in ICF/MRs declined by 7.2% between 1992 and 1995).<sup>8</sup>

For individuals with mental illness, federal Medicaid money is also available to the states to fund virtually all mental health services in the community, including psychiatric rehabilitative services, outpatient clinic services, case management, prescription drug services, and personal care services. *See* 42 U.S.C. §§ 1396d(a)(12), (13), (19), (14); 1396n(g); 42 C.F.R. §§ 440.90, 440.130, 440.167.<sup>9</sup> While Medicaid funding is available for community mental health services, state psychiatric hospitals are generally ineligible to receive Medicaid funding. *See* 42 U.S.C. § 1396d(a)(B). Therefore, it is financially advantageous for states to shift the provision of mental health services from state institutions to integrated settings. In addition, managed care options available under Medicaid give states discretion to implement innovative packages of community mental health services designed to reduce hospitalization. *See* 42 U.S.C. § 1396n(b).<sup>10</sup> These options make

<sup>8</sup> States actually save money by providing services in integrated settings to previously institutionalized individuals through the HCBS waiver program. Because the cost of community care is significantly less than the cost of institutional care, and the federal government contributes the same percentage of funding for each, states can provide services to a greater number of individuals with developmental disabilities at a smaller overall cost to the state.

<sup>9</sup> The federal match for these services is the same as the federal match for HCBS waiver services.

<sup>10</sup> Since 1990, when the ADA was enacted, the U.S. Department of Health and Human Services ("HHS") has become increasingly more permissive in granting states flexibility through the use of HCBS waivers and managed care waivers in their Medicaid programs. *See, e.g.,* GARY A. SMITH AND ROBERT M. GETTINGS, *THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY*, B4 (October 1994) (describing various Congressional amendments to the waiver program loosening restrictions on obtaining waivers); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262, 262-63 (Aug. 1996) (rapid growth of HCBS waiver programs between 1990 and 1996 a result of, among other things, federal administrative policy changes affording states greater latitude to expand waivers and cover a wider range of services); RESEARCH AND TRAINING CENTER ON COMMUNITY LIVING, INSTITUTE ON COMMUNITY INTEGRATION/UAP, RESIDENTIAL SERVICES

community-based services even more attractive from a fiscal standpoint.<sup>11</sup>

Because considerable federal money is available to help states fund community-based services for both people with developmental disabilities and mental illnesses, any costs associated with the transition to increased community care will not fall primarily on the states. Moreover, even if certain short-term costs were to fall on the states, this would not justify a refusal to provide community care to qualified individuals when such care is recommended by their treating professionals. Congress specifically contemplated imposing certain costs on the states and determined that such costs would not constitute a reason for non-compliance with the Act. The House Report on the ADA stated explicitly that "[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under...this title." H.R. REP. NO. 101-485 (III) at 49-50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 472-73. See also 135 CONG. REC. S4986 (daily ed., May 9, 1989) (statement of Senator Harkin)("Costs do not provide the basis for an exemption from the basic principles in a civil rights statute, like the ADA").

Courts have interpreted the ADA in a manner consistent with this legislative history. As a general rule, courts have held that "[i]nadequate state appropriations do not excuse noncompliance" with the ADA. *L.C.*, 138 F.3d at 904, quoting *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5<sup>th</sup> Cir. 1980). Thus, courts have forced states to fund compliance with the ADA regardless of the budgetary constraints facing those states. See, e.g., *Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*, 846 F. Supp. 986, 993 (S.D. Fla. 1994) (city must

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FOR PERSONS WITH DEVELOPMENTAL DISABILITIES: STATUS AND TRENDS THROUGH 1997 (Robert Prouty and K. Charlie Lakin eds., 1998) at 67 (cost neutrality requirements have been "considerably relaxed" since 1992).

<sup>11</sup>Other sources of federal funding are also available for community-based mental health services, such as federal block grant money for community mental health centers, see 42 U.S.C. §§ 300x *et seq.*, and federal subsidies for housing and support services. See 42 U.S.C. §§ 8011-8013.

continue to fund recreational programs for the disabled regardless of budgetary constraints; ADA's mandate that local governments provide equal opportunities for the disabled outweighs the public interest in having a balanced budget); *Kroll v. St. Charles County, Missouri*, 766 F. Supp. 744, 753 (E.D. Mo. 1991) (court justified in ordering an increase in property taxes in order to fund the changes necessary to make county courthouse handicapped accessible). These cases are consistent with the generally-accepted principle that the increased costs of complying with an anti-discrimination mandate do not constitute a valid excuse for failing to comply with that mandate. See, e.g., *Int'l Union, United Automobile Workers of America v. Johnson Controls, Inc.*, 499 U.S. 187, 210 (1991) ("the incremental cost of hiring women cannot justify discriminating against them" under Title VII).

#### D. Community Care Costs Less than Institutionalization.

Numerous studies comparing the costs and benefits of community care to institutionalization have concluded that community care is the more cost-effective way to provide services to people with disabilities. The annual cost of supporting an individual in the community under an HCBS waiver program is less than one-half the cost of treating that individual in an ICF/MR. See Smith and Gettings at 18. A study conducted for the American Journal of Mental Retardation in 1995 concluded not only that providing care to individuals with mental retardation in the community was more cost-effective than institutionalization, but also that state-owned institutions were the *most* costly mechanism for providing services. Edward M. Campbell and Laird W. Heal, *Government Cost of Providing Services for Individuals with Developmental Disabilities: Prediction of Costs, Rates, and Staffing by Provider and Client Characteristics*, AMERICAN JOURNAL OF MENTAL RETARDATION, July 1995 at 17-35. A study of the costs of treating 321 formerly institutionalized individuals with psychiatric disabilities in the community found that community-based services cost less than one-half as much as institutional care. Aileen B. Rothbard, et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up*



*Study*, AMERICAN JOURNAL OF PSYCHIATRY, December 9, 1998, at 2, 16 (total treatment cost in the community, including the cost of housing, was \$60,000 per person per year, compared to \$130,000 per person per year for institutional care). See also Herbert Bengelsdorf, et al., *The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service*, 181 J. NERVOUS & MENTAL DISEASE 757 (1993)(documenting considerable cost savings achieved by community-based services for individuals who otherwise would have been hospitalized).

In addition to being more expensive than community care, the cost of institutional care is rising. "During the 1992-96 period, the national average institutional daily costs [for people with developmental disabilities] advanced from \$210 to \$258." Adjusted for inflation, this represents a 10% increase over a five-year period. Braddock at 27. See also Lakin and Prouty at 4 (average annual state institution costs in 1980 were approximately \$30,000; by 1994, that cost had increased to approximately \$82,000). The cost of treating people with mental illnesses in institutions is also increasing. See REINVESTMENT OF RESOURCES at 2 (the rising cost of inpatient care at state psychiatric facilities has caused states to explore alternative community-based treatment).

A major reason that institutional care is so much more expensive than community care is the high cost of overhead. As total care environments, institutions must recreate many of the services that are part of the background of daily life. Thus, the provision of services in institutional settings "requires significant additional expenditures for facility and vehicle maintenance, utilities, and other fixed costs for the operation of separate facilities, as well as compensation for a workforce of cafeteria workers, janitors, and bus drivers." Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 464 (Summer 1991). Moreover, many institutions are aging and require significant capital expenditures to maintain. In the report issued in connection with the closure of a state-run hospital for people with developmental disabilities in Georgia, the state noted that it cost more than \$3.3 million each year just to maintain the hospital's buildings. Joint Appendix at 171. Developing community-based

services need not and generally does not require construction of new facilities. While large institutional facilities inevitably involve high construction and maintenance costs, developing community-based services is generally accomplished by simply making funding available to service providers to lease houses or other real estate.

Because community services are significantly less expensive than institutional care, states actually save money when they provide greater services in integrated settings. The savings are greatest in the case of individuals with developmental disabilities because of the widespread use of the Medicaid Home and Community-Based Services waiver program. Nationally, "[t]he average annual cost of supporting an individual in the HCB[S] waiver program is \$33,444 versus \$67,681 in the ICF/MR program." Smith and Gettings at 17-18. See also STATE OF OREGON, DEVELOPMENTAL DISABILITY HCB WAIVER APPLICATION, FY 1999-2004 (Oct. 1998), at App. G-6 (in 1999, the cost to the state of Oregon to serve a developmentally disabled person in the community is projected to be \$39,465, while it would cost \$99,930 to serve that same person in an institution). When states use HCBS waiver slots to move individuals from institutions to the community, they actually save money and are able to provide services to a greater number of disabled people. See Joint Appendix at 181 (state of Georgia will save money by closing institution for people with developmental disabilities, permitting the state to provide community services not only to all former institutional residents but also individuals on waiting lists for those services).<sup>12</sup>

<sup>12</sup> While many states are taking advantage of the savings potential of the waiver program, some states, including Georgia, could be realizing even more savings. Under the statutory scheme, states are permitted to determine how many individuals they will serve in their waiver programs, and HHS approves funding for that number of waiver participants. See 42 U.S.C. § 1396n(c). However, there are many states, including Georgia, that are not making full use of the waiver program that HHS has approved for those states. For example, as of 1996, Georgia had used only 700 out of 2100 slots eligible for Medicaid waiver funding. See Joint Appendix at 93. Thus, Georgia could have moved 1400 more people, including the respondents, from institutions to the community and could have saved money in the process. See Joint Appendix at 89.



The experience of individual states is instructive. The record in this case reflects that the average daily cost to treat an individual with a developmental disability in an institution in Georgia is \$267, compared to a daily cost of \$106 to \$181 to treat the person in the community. Joint Appendix at 171. In its current multi-year plan for the provision of services to people with mental retardation, the Commonwealth of Pennsylvania estimates that moving from institutionalization to more community-based care will save the state \$105 to \$140 million over a five year period. See PLANNING ADVISORY COMMITTEE TO THE OFFICE OF MENTAL RETARDATION, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, A MULTI-YEAR PLAN FOR PENNSYLVANIA'S MENTAL RETARDATION SERVICE SYSTEM (July 1997) at 11 ("Pennsylvania Multi-Year Plan"). In 1995, the state of Maryland estimated that closing an institution for people with developmental disabilities and placing the 165 residents in integrated settings would save the state \$1.2 million in 1996 and \$6.1 million in 1997. See DEVELOPMENTAL DISABILITIES ADMINISTRATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OPERATING BUDGET ANALYSIS (Feb. 8, 1995) at 19.

In Massachusetts, a commission appointed by the Governor found that providing care to both people with mental illnesses and developmental disabilities in community-based residential settings is a "highly desirable, highly effective, and less expensive" means of care. GOVERNOR'S SPECIAL COMMISSION ON CONSOLIDATION OF HEALTH AND HUMAN SERVICES INSTITUTIONAL FACILITIES, ACTIONS FOR QUALITY OF CARE (June 1991) at v. The Commission recommended closing and/or downsizing several state-run facilities and expanding community-based care. The Commission determined:

As a budgetary matter, the Commonwealth will realize substantial savings by placing appropriate consumers in residential settings. The costs for institutional services at mental health and mental retardation facilities can be \$100,000 per year per consumer. Community residential care ranges between \$30,000 and \$70,000, with an average annual per bed cost of \$55,000 for the provision of

residential day services as well as costs associated with real estate.

*Id.* at 29. The Commission ultimately determined that "[o]nce fully implemented, the net savings to the state are anticipated to be approximately \$60 million annually." *Id.* at vii.

The fact that community-based services are less costly than institutional care is further demonstrated by the factual findings made by the district court in this case. The court found that Georgia could provide services to L.C. and E.W. "at considerably less cost than is required to maintain them in an institution." As the court stated, "[t]he record establishes that, on an annual basis, institutional care for the mentally retarded costs more than twice as much as community care, and the same is true for the mentally ill." *L.C. v. Olmstead*, 1997 WL 148674, \*4 (N.D. Ga., March 26, 1997). See also *Helen L. v. DiDario*, 46 F.3d 325, 338 (3<sup>rd</sup> Cir.), cert. denied, 516 U.S. 813 (1995) (court found that moving the plaintiff from institutional to community care would save the state \$34,500 per year).

In addition, the cost-saving potential of caring for qualified individuals with disabilities in community settings was well documented when Congress enacted the ADA in 1990. For example, in its 1983 report, from which Congress derived key findings issued in conjunction with the ADA, the U.S. Civil Rights Commission stated, "[v]irtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care. Evidence suggests that alternative living arrangements allowing institutionalized residents to return to the community can save money." UNITED STATES COMMISSION ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM (1983) at 78 (footnotes omitted). See also David Braddock, et al., *Synthesis of Research on the Costs of Institutional and Community-Based Care*, JOURNAL OF MENTAL HEALTH ADMINISTRATION 171, 172-74 (Fall 1990) (describing several studies that found community care for people with developmental disabilities to be less costly than institutional care); Laird W. Heal, *Institutions Cost More Than Community Services*, AMERICAN JOURNAL OF MENTAL DEFICIENCY 121, 136 (1987) (1986 per diem institutional cost for a person with developmental disability was \$127, compared with

\$81 for community-based care). In 1984, Congress itself heard evidence of the cost savings incurred by moving individuals into the community. *See Joint Hearing on Recommendations to Improve Services for Mentally Retarded Citizens before the Subcommittee on the Handicapped of the Senate Committee on Labor and Human Resources and the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Senate Committee on Appropriations*, 98<sup>th</sup> Cong. 48 (1984) (statement of Sen. Weicker) (institutional care is "the most expensive care that you can give") and (statement of Ronald Melzer, director of Vermont Community Mental Retardation Programs) (based on experience in Vermont, "we can conclude that on a system-wide basis, community services are less costly than institutional care").

Community-based care is also more cost-effective than institutional care because of the positive benefits for those individuals treated in the community. Because these individuals interact with non-disabled people, learn job skills and learn how to cope in the "real world," they can cease to be an economic drain on society and instead become productive citizens who are more likely to achieve their full potential. Introducing the ADA in the Senate in 1989, Senator Harkin made a similar point:

[focusing] on the costs of compliance by covered entities totally misses the bigger picture. The economic benefits to society in terms of reductions in the deficit from getting people off of welfare, out of institutions, and on to the tax rolls cannot be ignored. This bill must be part of our overall strategy to get our Nation's economic house in order.

135 CONG. REC. S4986 (daily ed., May 9, 1989). Maintaining potentially productive individuals in institutions not only imposes the costs of care on the states but also imposes the costs of keeping individuals in "unjust, unwanted dependency." Cook, 64 TEMP. L. REV. at 458, *citing Americans with Disabilities Act: Hearing Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped*, 101<sup>st</sup> Cong. 66 (1989) (statement of Mr. Dart). *See also* 135 CONG. REC. S10,798 (daily ed., Sept. 7, 1989) (statement of Senator Simon) ("[T]here is simply no way to put a price tag on the lost dignity and independence

of people who want to be contributing members of their families, their communities, and their country."). Thus, Congress clearly understood that while the ADA might impose short-term costs on the states, the long-range effects of integration would create more productive citizens and benefit society as a whole. *See* Cook, 64 TEMP. L. REV. at 465.

Making the transition from institutional to community-based care will not impose additional costs on the states because most states have the necessary structures in place to make this transition. For example, all states require periodic evaluations to identify individuals who do not need institutional care and provide appropriate discharge planning for them, both as a matter of professional standards and as a matter of system planning. *See, e.g.,* GA. CODE ANN. §§ 37-3-64, 37-3-91; HAW. REV. STAT. § 333F-6. This information allows states to determine the types of services needed in the community and the approximate cost of those services. With such information, states are able to plan to downsize institutions in a cost-effective manner without admitting new individuals to fill the empty institutional beds. Many states have already transitioned from institutional to community-based care and, therefore, have gained substantial experience with such planning mechanisms. Pennsylvania's five-year plan for reshaping its mental retardation system is a prime example. In that plan, a state commission spelled out the steps necessary for the state to move effectively to more community-based care. The plan includes eight detailed recommendations including how the state can unify its system of funding mental retardation services, convert ICF/MR funding to HCBS waiver funding, and "[s]hift priorities for resource allocation from facility-based programs to services that build on natural supports." *See* Pennsylvania Multi-Year Plan at 6-12.

Moreover, states that have closed existing institutions as part of the transition to providing more care in the community have found creative ways to recover fixed costs invested in land and buildings. States have been very successful at converting closed institutions to alternative uses such as correctional facilities, juvenile detention centers, and other facilities for public uses. Lakin and Prouty at 5. *See also* Braddock at 28-29. Vast expanses of



public land on which institutions previously stood have been made available for local economic development, private industry, recreation and other local uses. For example, in Kansas City, Missouri, a state institution for the mentally retarded was converted into office space for use by other state government agencies, *see* Braddock at 29, and in Indiana, a state-run hospital was converted into a special treatment correctional facility. *See State to Close New Castle Center*, THE INDIANAPOLIS STAR, July 24, 1997, at B1. "Of all alternative uses, it seems at present the one of greatest favor is as correctional facilities. Corrections is a major growth industry in the United States, and offers substantial employment opportunities of similar pay and benefits to persons with backgrounds similar to the direct care staff of state institutions." Lakin and Prouty at 5.

Finally, although the move to community-based care may ultimately result in the closing of some state-owned institutions, it will not endanger the quality of care in the institutions that remain open. Instead, moving qualified disabled individuals, who do not need the restrictive care characteristic of institutions, into community care will likely improve the quality of care for those who remain institutionalized. The institution's treating professionals will be better able to provide appropriate care to fewer residents. In addition, although a smaller institutional population could increase the daily cost of an individual's care, the downsizing of the institution has a countervailing effect on its total budget. Thus, even when per capita costs increase, the reduction in total institutional population permits the institution to remain economically viable.

By requiring that individuals receive services in the most integrated setting appropriate to their needs, the Attorney General's integration regulation ensures that all types of care are available to people with disabilities. Because most states have already embraced the policy behind the integration regulation and currently provide most services for people with disabilities in integrated settings, enforcing the integration regulation will neither result in a significant change in state mental health or developmental disability systems, nor will it impose an unreasonable financial burden on the states.

## II. RESISTANCE TO COMMUNITY INTEGRATION IS THE RESULT OF HISTORIC DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES, WHICH IS PRECISELY THE SOCIAL ILL THE ADA AND THE INTEGRATION MANDATE WERE MEANT TO CORRECT.

Congress enacted the ADA in 1990 against the backdrop of a long history of discrimination against people with disabilities. Despite the petitioners' attempt to gloss over this unfortunate history, *see* Petitioners' Brief at 3-6, this Court has recognized that this country has subjected people with disabilities to shameful and humiliating treatment for hundreds of years. *See, e.g., City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 461 (1985) (Marshall, J., concurring in part and dissenting in part) ("the mentally retarded have been subject to a 'lengthy and tragic history' of segregation and discrimination that can only be called grotesque") (citations omitted). One of the most prevalent forms of discrimination against people with disabilities was, and still is, to segregate them from the rest of society by unnecessarily confining them in state-run institutions. Congress intended the ADA to end this form of discrimination, as well as all forms of discrimination suffered by individuals with disabilities. *See* 42 U.S.C. § 12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); 42 U.S.C. § 12101(b)(1) ("It is the purpose of this chapter to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."). The knee jerk opposition of the *amicus* states to the Eleventh Circuit's decision in the face of substantial evidence of the positive benefits of integration is likely caused by several factors, and is, at least in part, a piece of the legacy of discrimination against people with disabilities.

The overwhelming consensus of mental health professionals, including the *amici*, is that most individuals with developmental



disabilities and mental illnesses can be better treated in the community than in institutions. As David Braddock explained in his summary of state services for people with developmental disabilities:

[t]he efficacy of community living is grounded in research. Positive changes in functional skills or adaptive behaviors have been documented in numerous community integration studies and in the behavior analysis literature. Studies of family attitudes have also indicated that the great majority of parents of formerly institutionalized persons with mental retardation are consistently satisfied with the benefits of their relative's community living experience.

Braddock at 12. A study of the effects of deinstitutionalization on people with mental retardation concluded, based on eighteen studies conducted between 1976 and 1988, that people who move from state institutions to small community settings experience increased development in functional and adaptive skills. Sheryl A. Larson & K. Charlie Lakin, *Deinstitutionalization of Persons with Mental Retardation: The Impact on Daily Living*, JOURNAL OF ASSOCIATION OF PERSONS WITH SEVERE HANDICAPS 324 (March 1989). In fact, the state of Georgia has itself acknowledged the benefits of community care for treating people with developmental disabilities. In the written description accompanying the closure of a state-run institution, the Georgia Department of Human Resources noted:

[m]ore than 50 studies nationwide and our own experience in Georgia show that people with mental retardation who move from institutions to community services make dramatic gains. They learn a variety of daily living skills, have fewer behavior problems, usually have more contact with their families and are more satisfied.

Joint Appendix at 169-70.

The same can be said for treatment of people with mental illnesses. The "growing consensus within the mental health field [is]

that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting." Power Statement at 2. As with individuals with developmental disabilities, those people with mental illnesses who are treated in the community function with "greater independence...[and] express far greater satisfaction with their living situation and overall quality of life." Elizabeth C. McDonel, et al., *Downsizing State Operated Psychiatric Facilities: Three New Research Efforts to Examine the Quality of Community Care for Persons with Severe Mental Illness* (National Association of State Mental Health Program Directors Research Institute, Fourth Annual National Conference Proceedings, Jan. 1994) at 20. See also id. at 22 ("the literature has continued to pile up in favor of community alternatives [for people with mental illnesses]....There is certainly very little evidence suggesting that...long term hospitalization is a good idea, and clear indications that it is actually harmful."); Rothbard and Kuno, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY at 3-4 (describing several studies that found considerable improvement in social interaction and overall functioning level of formerly institutionalized people with mental illnesses receiving treatment in the community).

The experience of treating professionals included in the record is consistent with the findings of the national studies. See, e.g., Affidavit of Diane Cobb, Joint Appendix at 132 ("In my experience, persons with mental retardation and mental illness, especially if they have been frequently institutionalized, often have long-standing behavior problems which can be more effectively addressed in the community where the individual can form a consistent relationship with one or two trained staff in a supportive environment."). In sum, there is now a clear consensus among researchers and other professionals that services in community settings produce better results for individuals with disabilities than does institutional care. See Cook, 64 TEMP. L. REV. at 413; Braddock at 12-16.

Notwithstanding the treatment and cost benefits of community care compared to institutional care, the petitioners and the *amicus* states have objected strenuously to the enforcement and implementation of the integration regulation. The available evidence,

and the experience of the *amici*, suggests that there are several factors that likely explain the motives behind their objections. One likely contributing cause is historical discrimination against people with disabilities. *See Cleburne*, 473 U.S. at 461-65. An additional reason is the stigma surrounding mental illness, which has historically generated opposition to community placement in residential neighborhoods for both people with developmental disabilities and those with mental illnesses, further complicating the development of housing and employment opportunities. *See* Power Statement at 3. Community residents often resist efforts to create group homes for people with disabilities, contending that the disabled residents will engage in "unruly behavior," cause property values to decline, or harm other residents. Marianne Comfort, *Disabled Neighbors Joining in Daily Life*, AKRON BEACON JOURNAL, Feb. 2, 1997, at G3. *See also Finding a Place for the Mentally Ill*, BOSTON GLOBE, Jan. 31, 1996, at 12 ("nearby residents say they are afraid just to walk past the group home" for people with mental illnesses); John Richardson, *A Struggle to Fit In*, MAINE SUNDAY TELEGRAM, Dec. 1, 1996, at 1A (describing a community protest against an existing group home for individuals with mental illnesses in which a protester cut off a sewer line and filled the home with raw sewage, forcing the residents to evacuate).

This "not in my backyard" objection to community-based care was dramatically displayed in the city ordinance challenged in the *Cleburne* case. The City of Cleburne, Texas required a special zoning permit for a home for people with mental retardation that it did not require for other multiple occupancy dwellings. 473 U.S. at 436. One of the city's reasons for requiring the special permit was the "negative attitude" of the majority of property owners located near the proposed home and the fears of those residents. *Id.* at 448. This Court properly held that "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for the mentally retarded differently from apartment houses, multiple dwellings, and the like." *Id.*

Congress intended the ADA to dispel the fear and stereotypes about people with disabilities by encouraging interaction between disabled and non-disabled persons in daily life. One important

means of encouraging this interaction is by permitting qualified people with disabilities to live in community facilities, with appropriate care and support, surrounded by disabled and non-disabled people alike. Greater inclusion of people with disabilities benefits both disabled individuals and society as a whole. *See* 136 CONG. REC. H2603 (daily ed., May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared. If we have learned any lessons in the last 30 years, it is that only by breaking down barriers between people can we dispel negative attitudes and myths that are the main currency of oppression."); Cook, 64 TEMP. L. REV. at 448-49 ("It is well documented that when peers with and without disabilities receive accurate information about one another and are provided with opportunities to interact with one another on an ongoing basis, social acceptance occurs. The research demonstrates that these types of...interactions lead to greater tolerance for diversity and difference by persons without disabilities.").

Local economic and political interests are an additional reason states continue to overutilize institutions as one method of caring for people with disabilities, even in the face of the overwhelming evidence that community placement is preferred by treating professionals and is less costly. Often, influential state legislators whose constituents' jobs or profits depend on institutions prevent or delay downsizing or closure. *See* SUSAN STEFAN, DISCRIMINATION AGAINST PEOPLE WITH PSYCHIATRIC DISABILITIES (forthcoming 1999) at Ch. 9, n. 55 ("In Montana, the State Legislature resisted the efforts of the State Department of Institutions to close its facility for people with mental retardation openly on the grounds that even if closure would improve the lives of the residents at the institution, people in the surrounding area needed the jobs."). Labor unions have also been a vocal and influential force in keeping institutions open, even in the face of evidence demonstrating that closure might be sound economic and mental health policy. *See* Mental Health, United States, 1996 at 103 ("Confounding the options of policy makers are economic pressures brought by communities and labor unions to keep the state and county mental hospitals open [and] to increase their size."). Unions like the American Federation of State, County and Municipal Employees ("AFSCME") have often stridently resisted



state efforts to move to community care in order to protect its members' jobs. AFSCME has only supported the downsizing or closing of institutions in states where community services were to be provided by the state itself rather than by private providers, thereby protecting the jobs and wages of AFSCME members. See AFSCME PUBLIC POLICY DEPARTMENT, AFSCME AND THE MENTALLY DISABLED: INSTITUTIONS TO COMMUNITY CARE (June 1992) at 9.

While labor unions may have legitimate concerns about the stability of their members' jobs, a civil rights statute like the ADA and its implementing regulations cannot be held hostage to such political or parochial interests. The type of care to be provided to an individual should be determined by the individual's particular needs and his or her civil rights, not the desires of a labor union or any other interest group. The integration regulation, by requiring a state to provide services to an individual in the most integrated setting appropriate for his or her needs, properly implements this principle.

Finally, bureaucratic inertia is the reason for reluctance on the part of some states to embrace fully the mandate of the integration regulation. States have been caring for their citizens with disabilities in large institutions for more than one hundred years, and many institutional administrators have resisted making changes in the status quo. After all, providing services to individuals with disabilities in the community requires more commitment, creativity, and innovation than simply congregating large groups of individuals with vastly different disabilities in a few state-run institutions. The record in this case reflects that the state of Georgia took a long time to find community placements for the respondents largely because of neglect and bureaucratic inertia. See, e.g., Joint Appendix at 118-19 (series of memoranda over the course of four months describing lack of progress in finding treatment for E.W. in the community).<sup>13</sup>

<sup>13</sup> Another example of such inertia was noted by the court in Helen L., 46 F.3d at 337-38, in which the state offered "administrative convenience" as a reason for not placing the plaintiff in community care.

In sum, the Attorney General's integration regulation is a reasonable construction of the ADA that will not have catastrophic financial implications for states that might have to increase the speed with which they transition to community treatment. Nor will it have dramatic social implications in the form of the careless release of severely ill individuals into the community without proper care and support. Instead, it represents sound civil rights, mental health and fiscal policy, and it reflects the direction in which the majority of state providers of care are already moving. The factors that contribute to the *amicus* states' and the petitioners' opposition to the Eleventh Circuit's decision, such as past discrimination, local political and economic interests and bureaucratic inertia, are unacceptable reasons to keep potentially productive citizens unnecessarily confined to institutions and prevent them from reaching their full potential.

## CONCLUSION

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted.

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MARCH 15, 1999

## APPENDIX

### Deborah Allness

Deborah Allness was director of the Wisconsin Office of Mental Health from 1986 to 1990. She was a co-developer of the PACT model, an intensive community-based treatment and rehabilitation program for persons with severe and persistent mental illness. She co-authored the groundbreaking manual, *The PACT Model of Community Based Treatment for Persons with Severe and Persistent Mental Illness*, which was sponsored by the National Alliance for the Mentally Ill. For Wisconsin, Allness wrote and promulgated standards for PACT-like programs and established it as a Medical Assistance (MA) benefit, creating a financial incentive for the state's counties to implement the program. Since her service in state government, Allness consults with states and providers in the development of community treatment and financing under MA and managed care.

### Dennis G. Amundson

Dennis Amundson served as California's Director of the Department of Developmental Services from 1991 through 1997. During this period, the Department successfully reduced the institutional population from 6,800 to less than 4,000. The reduction enabled the state to close two large state institutions and transfer cost savings to expand community-based options for persons with developmental disabilities. Between FY 1991-92 and FY 1997-98, California's community system grew from serving 103,000 individuals with developmental disabilities to more than 140,000. The community budget grew during this period from \$646 million to nearly \$1.2 billion, with nearly \$400 million of this increase generated from federal waiver authority.

### C. Patrick Babcock

For more than five years, Patrick Babcock served as the Director for the Michigan Department of Mental Health before becoming the Director of the Department of Social Services. As the state official responsible for the delivery of mental health services, Babcock oversaw community mental health services that included 55 community mental health boards serving all 83 Michigan counties. He also was responsible for community residential serv-



ices for former residents of state facilities for persons with mental illness and developmental disabilities. Babcock is the Director of Public Policy for the W.K. Kellogg Foundation, where his duties include serving as Project Director of a health reform project in three Michigan communities.

#### **Joseph J. Bevilacqua, Ph.D.**

Joseph Bevilacqua has twenty-one years experience as State Commissioner of Mental Health Services in Rhode Island, Virginia, and South Carolina. He also served as Assistant Commissioner for Community Services for four years in Virginia. Prior to state service, Bevilacqua served in the United States Army as a social work officer working in psychiatric hospitals and Mental Health Clinics both in the states and overseas. Throughout Bevilacqua's career he has been actively affiliated with a number of academic institutions, including appointments at the University of Virginia, Brown University, Medical College of Virginia, University of South Carolina, and Medical University of South Carolina. He used his state role to encourage collaboration between the University and Departments of Mental Health. This collaboration included research projects, student placements in state programs and faculty consultation in major state initiatives such as community development and hospital downsizing. He has also written a number of publications in the field of mental health.

A major priority of Bevilacqua's commissionership has been active and strong support of consumers of mental health services. He worked hard to actively engage them in advocacy as well as advisors to mental health providers, encouraged self-support and consumer independence, and strongly promoted consumers to be active and paid staff members to provider organizations including public mental health systems. Bevilacqua served two terms as President of the National Association of State Mental Health Program Directors and currently serves on the Board of Directors of the Human Services Research Institute, Boston; the Center for Study of Issues in Public Mental Health, Albany; Fellowship Health Resources, Lincoln, Rhode Island; The Green Door, a psychosocial rehabilitation program in Washington, DC; and National Alliance for the Mentally Ill-Rhode Island.

#### **Gerald A. Born**

Until January 1998, Gerald Born had been in state service for 27 years. He was variously the Director of the Wisconsin Bureau of Developmental Disabilities, Administrator of the Division of Community Services, and the Assistant Administrator in both the Division of Care and Treatment Facilities and the Division of Community Services. Born has also been a university faculty member and an administrator of both public and private facilities for people with mental retardation. In 1998, Born was hired as the Executive Director of The Arc-Wisconsin, a statewide advocacy organization that serves people who have developmental disabilities and their families.

#### **Geraldine Botwinick**

Geraldine Botwinick became the Acting Division Director of the New Jersey Department of Human Services Division of Mental Health and Hospitals after serving many years as the Deputy. During her tenure as Deputy and Acting Director, Botwinick developed a regionalization plan to reorganize and unify hospital and community mental health services and executed New Jersey's first contract for consumer-run services. Botwinick also spent three years as the Director of Community Services for New Jersey, managing the statewide community mental health system. In this position, she doubled the state funding base for community services by utilizing methods such as the state's first community capital bond issue and securing a federal Housing and Urban Development demonstration grant for the chronically mentally ill and a Community Support Grant from the National Institute for Mental Health. Botwinick is an independent consultant and owner of the Strategic Consulting Group.

#### **James Donald Bray, M.D.**

Donald Bray oversaw the Oregon Mental Health Division from 1971 to 1979. After retiring from Oregon state government in 1989, he was a Visiting Scholar with the South Carolina Department of Mental Health. He has served as a mental health con-

sultant to the National Institute of Mental Health and the following states: Illinois, Utah, Alabama, Idaho, and Kentucky. Bray currently works as a consultant to the South Carolina Public-Academic Mental Health Consortium and the Department of Mental Health. Bray's career has been primarily focused on developing community-based services for people with severe mental disorders and developmental disabilities.

#### **Philip Campbell**

Philip Campbell served as the Commissioner for the Massachusetts Department of Mental Retardation from 1991 to 1997. Campbell provided leadership during a major public policy transition to a community-based system of supports. His accomplishments included an increase in federal Home and Community Based Services waiver support from \$28 million in 1991 to \$133 million in 1997, closure of three public institutions, and completion of disengagement from 21-year-old federal court involvement in five federal consent decrees. Campbell's efforts reduced the state's net cost of serving persons with developmental disabilities by 6% while the number of persons served increased by 15%. Campbell is the Chief Executive Officer of Family Services of Western Pennsylvania.

#### **Robert L. Carl, Jr., Ph.D.**

During Robert Carl's approximately 17 years as head of Mental Retardation/Developmental Disabilities Services in Rhode Island, he created community alternatives for all institutionalized persons. Rhode Island was the first state to promulgate a policy to close all public Mental Retardation/Developmental Disabilities institutions. Under Carl's leadership, the state developed the most comprehensive community based system in the nation. All eligible persons receive service. There is no waiting list, and no persons are sent out-of-state for service. Prior to his position in Rhode Island, Carl was Deputy Commissioner for the Ohio Department of Mental Health and Mental Retardation. Carl currently serves as the Director of the Rhode Island Department of Administration and reports directly to the governor.

#### **Kevin W. Concannon**

Kevin Concannon became Commissioner of the Maine Department of Human Services in February 1995. He was previously Director of the Oregon Department of Human Resources for eight years and Administrator of the Oregon Mental Health and Developmental Disability Services Division for a period of months. From 1980 to 1987, he was Commissioner of the Maine Department of Mental Health and Mental Retardation and was Director of the Maine Bureau of Mental Retardation from 1977 to 1980. He worked for a number of years in private social welfare as Regional Administrator and Associate Director of a statewide social and health services agency.

Concannon has held a number of national leadership roles, including President of the National Association of State Mental Health Program Directors from 1987 to 1988. He was a member of the National Academy of State Health Policy Commission on Vulnerable Populations, is Chair of the New England States Consortium on Medicaid-Medicare dual eligible service populations, and was the Maine team leader for the Danforth Foundation Policy Makers Program. He has also served on various national advisory groups, such as the Joint Commission on Accreditation of Hospitals, the Kennedy School of Government at Harvard University's Advisory Group on Mental Health Leadership, and the State Human Resource Development Center Advisory Council at the National Institute of Mental Health.

#### **Robert J. Constantine**

Robert Constantine spent many years working in mental health for Florida state government.

He served as the State Mental Health Program Director in the early 1980's, was the chief administrator for several psychiatric facilities, and later returned to state government to serve as the State Director of Alcohol, Drug Abuse and Mental Health Programs. Constantine is the President and Chief Executive Officer for the Florida Council for Behavioral Healthcare.



### **King Davis, Ph.D.**

King Davis served as Commissioner of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services from 1990 through 1994. During that period, a major priority of the department was the placement of individuals with disabilities in the community. A number of initiatives were developed to increase the success of community placements. The Commonwealth of Virginia's commitment to community placements extends as far back as 1968 with the development of the Community Services Act. Additionally, in response to efforts by the U.S. Justice Department to ensure compliance with the Civil Rights of Institutionalized Persons Act, the Governor, Attorneys General, and the legislature supported the Department of Mental Health's efforts to decrease its reliance on institutions in favor of community-based strategies of care. This strategy included specific placement of a fixed number of institutionalized residents with mental retardation at the Northern Virginia Training Center in local communities. This community-based strategy became the accepted policy direction of the Commonwealth of Virginia. Davis is the William & Camille Hanks Cosby Professor at Howard University.

### **Jan Duker, Ph.D.**

Jan Duker has worked professionally in the mental health and mental retardation fields for almost 40 years. During her career, she served as Executive Director of the Mississippi State Department of Mental Health and Mental Retardation from 1980 to 1986. Duker also spent five years as Executive Director of the Mental Health Mental Retardation Authority (MHMRA) of Harris County in Houston, Texas, the largest community-based authority in the country. Under Duker's leadership, MHMRA provided a full range of public mental health and mental retardation services, including residential services, in the 1,700 square mile county area.

In addition, Duker has chaired committees for the National Association of State Mental Health Program Directors and been a grant reviewer and state plan reviewer for the National Institute for Mental Health. She has also served as a consultant to states for

issues such as community services, managed care, and children's services.

### **Steven M. Eidelman**

As the Director of Pennsylvania's mental retardation/developmental disabilities program from 1987 to 1993, Steven Eidelman was responsible for leadership and management of all community and institutional services for 65,000 residents. During his tenure, he managed the largest Medicaid waiver for long-term care project in the United States. Eidelman also developed new programs and services in the areas of support services to families, early intervention and employment of persons with disabilities. He left state government to become Executive Director of the Joseph P. Kennedy, Jr. Foundation and also served as the Interim Executive Director of the American Association of University Affiliated Programs, a national trade association for 70 major research universities engaged in training, exemplary and demonstration service projects, and research in the fields of developmental disabilities and related disorders. Eidelman was recently named Executive Director of the national Arc, formerly the Association for Retarded Citizens of the U.S.

### **Eileen Elias, M.Ed**

Eileen Elias was the Commissioner of Mental Health for the Commonwealth of Massachusetts from 1991 to 1996, where she transformed the State's state hospital-based mental health system into a national model of an integrated, comprehensive community-based service system. In addition, she revamped and restructured public and private behavioral health acute and continuing care services to become organized systems of community-based care in the District of Columbia (1997, Acting Commissioner for the Commission on Mental Health Services); Massachusetts Department of Mental Health (1988 to 1991, Area Director and 1991 to 1996, Commissioner); New Jersey (1981 to 1983, Greater Trenton Mental Health Center Director of Case Management & 1984 to 1988, New Jersey Division of Mental Health, Central Region Director and State Director of Core Services); Rhode Island

(1983 to 1984, Kent County Community Mental Health Center, Chief of Community Support Services); and Pennsylvania (1971 to 1981, Horizon House Psychosocial Program, an array of positions inclusive of case manager, Director of Case Management).

Elias has published a breadth of publications on the subject of organizational change and is a recognized speaker and consultant on a variety of subjects relating to organizational change, facility consolidation, managed care, and consumer empowerment. She presents at regional, national and international workshops and conferences and is an invited speaker at academic institutions including Harvard University Kennedy School of Government and the Massachusetts Institute of Technology Sloan School. Elias is currently a Systems Consultant for the federal government's Substance Abuse and Mental Health Services Administration and CPC-Chestnut Lodge, a non-profit, nationally known psychiatric service center.

#### **Sue Elliott**

Sue Elliott was Director of the Washington State Division of Development Disabilities from 1987 to 1993 and the Planning and Evaluation Manager for Arizona's developmental disabilities agency from 1976 to 1980. During her tenure in state government, Elliot developed and implemented plans for the movement of over 700 persons out of state institutions and nursing homes into community alternatives. Other accomplishments include: developing and implementing plans to reduce state expenditures by \$8.2 million, as directed by Governor; negotiating successful agreements with state labor unions; gaining legislative approval for and directed implementation of the closure of one of three state-operated institutions in Arizona and Interlake School in Washington for the developmentally disabled; and expanding community-based system of services offering alternatives to institutionalization for persons who were developmentally disabled.

#### **Mary Jane England, M.D.**

As the first commissioner of the Massachusetts Department of Social Service (DSS) from 1979 to 1983, Mary Jane England

helped establish and administer a new state agency for children and their families. Before her appointment at DSS, she served as the Associate Commissioner of the Massachusetts Department of Mental Health and Mental Retardation.

In 1995, England served as president of the American Psychiatric Association, and she is a past president of the American Medical Women's Association. She serves as the Vice President of the National Academy of Public Administration, the American College of Psychiatry, the American College of Mental Health Administration, and the Group for the Advancement of Psychiatry.

England also served on the Board of Overseers for the U.S. Department of Commerce, Malcolm Baldrige National Quality Award and currently serves on the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration National Advisory Council and the National Institute of Mental Health Advisory Council. She currently serves on the President's Quality Forum Planning Committee.

England was also associate dean and director of the Lucius N. Littauer Master in Public Administration (MPA) Program at the John F. Kennedy School of Government, Harvard University. Dr. England is the chair of the Board of Visitors of Boston University School of Public Health and a member of the Board of Visitors of Boston University School of Medicine. England is president of the Washington Business Group on Health, a nonprofit national health policy and research organization whose membership includes the nation's major employers.

#### **David L. Evans**

From 1990 to 1993, David Evans was the Director for Georgia's Division of Mental Health, Mental Retardation and Substance Abuse. Prior to his service in Georgia, Evans was the State Director for the Office of Mental Retardation for Nebraska and Acting Director of the Community Services Division for Developmental Disabilities in Michigan. A past president of the National Association for State Mental Retardation Program Directors, Evans is the Executive Director of the Austin-Travis County Mental Health Mental Retardation Center in Austin, Texas.



### **Jaylon L. Fincannon**

As Director of Mental Retardation Services in Texas for 13 years, Jaylon Fincannon was instrumental in the development of a comprehensive community service system, improvements in state-operated facilities, closure of two state-operated institutions and dismissal of a 21-year-old class action lawsuit. He currently serves as a member of a three-person Quality Review Panel established in Tennessee to oversee the state's planned improvements in the community service system and three of the state's developmental centers. The Panel was established as part of the state's compliance with the Settlement Agreement of a class action lawsuit. Fincannon not only provides monitoring of the improvements, but also provides technical assistance to all aspects of the improvement process. He is also currently providing consultation to the Division of Services for People with Disabilities, Utah Department of Human Resources.

### **William Goldman, M.D.**

William Goldman is a former Commissioner of Mental Health and Mental Retardation for Massachusetts. He also served as the Director of Mental Health, Drug and Alcoholism Services for the city and county of San Francisco. Throughout his career in mental health, Goldman strived to provide services for people with mental illness in the least restrictive environment by attaching resources to the individual rather than the institution.

Goldman is currently the Senior Vice President for Behavioral Health Sciences at United Behavioral Health and a Clinical Professor of Psychiatry at the University of California, San Francisco. He serves on the University of California Los Angeles/Rand Research Center on Managed Care for Psychiatric Disorders Advisory Board and is a member of the National Institute for Mental Health Program Research Advisory Group and the Parity Workgroup. Goldman is also a member and immediate past Chair of the American Psychiatric Association Council on Economic Affairs.

### **Dennis Harkins**

From 1987 to 1997, Dennis Harkins was director for services to people with developmental disabilities in Wisconsin. He has been involved in the deinstitutionalization of people with developmental disabilities and in helping create community living for all people with disabilities since 1972. During his career in Wisconsin state government, Harkins developed and implemented creative and effective statewide programs for people with developmental disabilities that continue to serve as models for other states and countries. He currently remains active in working on this issue as a private consultant to local, state and national organizations.

### **Ken Heinlein, Ph.D.**

Ken Heinlein has more than 20 years experience in the field of developmental disabilities, including direct services to adults with developmental disabilities in community-based vocational and residential settings and eight years in the administration of Wyoming's developmental disabilities system serving infants, toddlers, and preschool aged children and adults with disabilities. In Wyoming, he served as Director of the Department of Health and Social Services and Director of Department of Health, both of which oversaw the department of developmental disabilities. Heinlein is the Director of the Outcome Research Center for the Wyoming Institute for Disabilities/University Affiliated Program at the University of Wyoming where he conducts research in post-institutional placements, including the cost and quality of community-based supports and services for persons with developmental disabilities.

### **Donald J. Hevey**

From 1982 to 1985, Donald Hevey served as the Director of the Alcohol, Drug Abuse and Mental Health Program Office for the State of Florida. In this position, he was responsible for directing, regulating and contracting for the statewide administration of all community alcohol, drug abuse and mental health programs and institutional mental health, substance abuse and forensic pro-

grams. He also served as the Assistant Director of this office in 1981 to 1982. Prior to his service in state government, Hevey served as the Chief Executive Officer of the Manatee County Community Mental Health Center in Bradenton, Florida, where he was responsible to a community board of directors for the management and administration of a comprehensive mental health and substance abuse center. Hevey presently serves as President and Chief Executive Officer of Mental Health Corporations of America.

#### **Elin Howe**

Elin Howe has 24 years of experience in the field of Developmental Disabilities, including almost four years as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities. As Commissioner, she was responsible for policy development, planning, financing, regulating, managing, and providing services to the approximately 75,000 New York State citizens with mental retardation and developmental disabilities. Howe has provided consultation services on developmental disabilities issues in five states including: New Mexico, Indiana, California, Iowa and Georgia. In addition, Howe has extensive experience in working with parents, consumer and advocacy group services, providers and boards of directors, community and legislative relations in human resources management, including labor relations, labor organizations, cultural diversity issues, in budgetary process and in development and implementation of total quality management initiatives.

#### **Jennifer L. Howse, Ph.D.**

Jennifer Howse has held a number of key executive positions in health-related organizations, including those of State Commissioner for Mental Retardation in Pennsylvania and Associate Commissioner in the New York State Office of Mental Retardation and Developmental Disabilities. After leaving state government in 1986, Howse joined the March of Dimes, serving as the Executive Director of the organization's Greater New York Chapter and becoming president of the March of Dimes Birth Defects Foundation

in 1990. She serves on the board of The Salk Institute for Biological Studies and chairs the Advisory Board of The Center for Family Life. She is a member of the Kaiser Commission on Medicaid and Uninsured, and the Advisory Committee to the Director, Centers for Disease Control and Prevention. Howse is the recipient of the Human Dignity Award from the Henry H. Kessler Institute and the Leadership in Health Care Award from the Pace University School of Nursing.

#### **Pamela S. Hyde, J.D.**

Pamela Hyde was appointed by Governor Richard F. Celeste as the Director of the Ohio Department of Mental Health, and later the Ohio Department of Human Services, the state's Medicaid and child welfare agency. She served as the Director of the Seattle Department of Housing and Human Services, and then was recruited as President and Chief Executive Officer of ComCare, a Phoenix-based behavioral health managed care company. Hyde is trained as an attorney and also spent several years as an advocate and executive director of a statewide protection and advocacy agency. Hyde is presently a Senior Consultant with the Technical Assistance Collaborative, Inc., a Boston-based non-profit organization founded by the Robert Wood Johnson Foundation to assist state and local governments and non-profit agencies meet the changing demands of the behavioral health, housing, child welfare, and human services fields.

#### **Dennis R. Jones, M.S.W., M.B.A.**

Dennis Jones was Commissioner of Mental Health in Indiana from 1981 until 1988. He was then Commissioner for the Texas Department of Mental Health and Mental Retardation for six years. Both of these positions included institutional and community responsibility for mental retardation as well as mental health.

#### **Martha Boatman Knisley**

Martha Knisley's 29 years of experience in mental health and mental retardation programs include serving as Commissioner of



Mental Health for the Commonwealth of Pennsylvania and as Director and Deputy Director of the Ohio Department of Mental Health, where she developed strategies for downsizing facilities. Presently, she is a senior consultant with the Technical Assistance Collaborative (TAC). At TAC, her primary focus is in assisting state and local organizations in the development of community support programs for adults with serious mental illness, special needs housing, development of business and organizational plans for managed care, workforce development and training, board training, and community development.

#### **Brian Lahren, Ph.D.**

Brian Lahren worked in the Nevada Division of Mental Health and Mental Retardation for 12 years, serving as commissioner from 1988 to 1992. He resigned from his position in protest over budget cuts which reduced community services and became Executive Director of the Washoe Arc. Since leaving state employment, Lahren has worked successfully to reestablish Nevada's community-based services, using statewide advocacy to ensure that the legislature restore the lost funding. Nevada now has the lowest rate of institutionalization in the United States for persons with mental retardation and developmental disabilities and is near the bottom in per capita institutionalization for individuals with mental illness.

#### **Brian R. Lensink**

Brian Lensink has managed developmental disabilities service systems in two states, Colorado and Connecticut. He has also provided consultation and support to the governments of Tennessee, Oklahoma, Kentucky, and Utah. As a consultant, Lensink has assisted states and counties with the development of community services and supports. He has published numerous articles and made many presentations on serving persons with developmental disabilities in integrated settings. Lensink continues to provide consultation services throughout the United States and in the Netherlands in a variety of areas, including institutional downsizing and closure strategies.

#### **John C. Lewin, M.D.**

From 1986 to 1994, John Lewin was Hawaii's Director of Health, overseeing 6,500 staff and a nearly \$1 billion annual budget. His responsibilities included Chief Executive Officer (CEO) and Director of the state Mental Health System, including comprehensive inpatient, outpatient, community, and preventive mental health; adolescent inpatient, outpatient, and community mental health; children's mental health services; and comprehensive substance abuse treatment and rehabilitation services. As Director of Behavioral Health Services, Lewin helped to deinstitutionalize the majority of patients at the old and unaccredited Hawaii State Mental Hospital, building a much smaller rehabilitation-oriented hospital with community-linked services, accreditation, and training programs for nurses, psychologists, and psychiatrists in partnership with the University of Hawaii. Lewin is Executive Vice President and CEO of the 35,000-member California Medical Association.

#### **David E. Loberg, Ph.D.**

David Loberg was appointed Director of the California Department of Developmental Services in 1978. During his five-year tenure, he oversaw a \$600 million budget and 18,000 employees in the provision of needed services for individuals with developmental disabilities. Since 1986, he has worked as a principal consultant with Dataserve, providing management consultation, psychological services, and data analysis services to a variety of health facilities, residential facilities, and human service programs in the North Bay and East Bay areas. Loberg is also a lecturer in psychology at Napa Valley College.

#### **Danna Mauch, Ph.D.**

Danna Mauch served as Director of Mental Health for the State of Rhode Island, Assistant Commissioner of Mental Health for Massachusetts and Executive Director of an ambulatory and long-term care provider. In the Commonwealth of Massachusetts, she directed the Divisions of Forensic Medicine, Mental Health

and Substance Abuse. Until recently, she served as the Special Master for the United States District Court for the District of Columbia, evaluating the implementation of reforms to the publicly-financed mental health system in the nation's capital. In her government roles, Mauch effected major systems changes in the provision of psychiatric care. As a result, Rhode Island's Mental Health System was rated number one in the nation by the Public Citizen Health Research Group.

Mauch served as member of the National Advisory Board of the U.S. Center for Mental Health Services and co-chaired a health care reform task force on behavioral health for the Labor and Human Resources Committee of the U.S. Senate. She was also Principal Investigator on a number of federal and foundation-funded research and demonstration projects in the mental health and long-term care fields. She has published several key articles and book chapters on the management of care and public/private partnerships in service delivery and systems management for the behavioral health care industry. Mauch is currently the Chief Executive Officer of Magellan Public Solutions, Inc., a health care organization with the capacity to deliver specialty care management solutions to the public sector.

#### **Neil Meisler**

Neil Meisler directed the Rhode Island Division of Mental Health from 1980 to 1984. He left the position to become the Director of Public Mental Health Services at the Southern Illinois University School of Medicine. At the university, Meisler implemented a public sector psychiatric residency rotation through affiliation of the Department of Psychiatry with a state hospital and a community mental health center. He also developed and directed a model program of assertive community treatment for persons with severe psychiatric disabilities. In 1986, Meisler became responsible for the day-to-day operations of the South Carolina Department of Mental Health, and from 1988 to 1993 he served as state commissioner for mental health in Delaware. Meisler is Assistant Professor of Psychiatry and Administrative Director of the Division of Public Psychiatry at the Medical University of South Carolina.

#### **Ronald Melzer, Ph.D.**

Ronald Melzer has 20 years of senior level management experience in the provision of mental health and developmental disabilities services. Melzer served 13 years in Vermont state government, including two years as the Director of Mental Retardation Programs. In Vermont he developed a comprehensive plan for replacing the state's institutions with an integrated network of community-based services and obtained a federal Medicaid waiver that enabled funding to follow clients. From 1987 to 1989, Melzer was the Deputy Director of Community Services for the New Jersey Division of Developmental Disabilities, and from 1989 to 1995, he oversaw quality assurance for mental health programs in the city of New York. From 1995 to 1998, as Vice President for Public Sector Program Development at Merit Behavioral Care Corporation, Melzer designed and implemented cost-effective, community-based alternatives to institutional programs.

#### **Marvin L. Meyers**

Marvin Meyers became Commissioner for Mental Retardation for Northeastern Pennsylvania in 1978. He came to Pennsylvania from Colorado where he served as State Director of Mental Retardation for the Colorado Department of Institutions for more than five years. In Colorado, he also held other positions such as State Director of Community Services for Institutions and State Supervisor of Programs for the Mentally Retarded for the State Department of Education.

During Meyers' tenure with the Department of Institutions, he reduced the institutional population by 25% in a five-year period while the state experienced growth of 11%, promoted institutional reforms and deinstitutionalization, and helped to establish 110 agencies in the community to provide residential and day services for people with mental retardation of all ages. He also served as a consultant to public and private non-profit agencies throughout the west and mid-west in matters relating to program development, administration and management. He initiated Colorado's first



comprehensive community-centered program for the individuals with mental retardation.

#### **Karen L. Middendorf**

Karen Middendorf served for two and one half years, from 1995 to 1997, as Director of the Division of Mental Retardation in the Kentucky Department for Mental Health and Mental Retardation Services. Her 28 years in the field of mental retardation-developmental disabilities services has included 13 years as the Mental Retardation/Developmental Disabilities Director for Comprehend Inc., the Regional Mental Health-Mental Retardation Board in Maysville, KY and 13 years in a variety of positions at the Human Development Institute-University Affiliated Program at the University of Kentucky, including Director of Outreach Services and Associate Executive Director. In these various positions Middendorf developed community services and supports for individuals with disabilities and their families; provided training and technical assistance to agency personnel at local, state and national levels, developed and taught interdisciplinary courses at the graduate and undergraduate level; promoted interagency coordination and collaboration; and both advocated for and developed public policy that supports choice and inclusion for all citizens.

Middendorf is a Fellow of the American Association on Mental Retardation and served as President of the National Association in 1995, as well as holding numerous other leadership positions in the state, regional, and national levels of the organization. She has served on numerous boards and task forces at state, regional, and national levels and been honored by a number of associations for her contributions to the positive change in services and supports for individuals with disabilities over the last 20 years.

#### **Dennis F. Mohatt**

Dennis Mohatt is the former Deputy Director of the Nebraska Department of Health and Human Services and the state's designated mental health commissioner. He was also the Executive Director of the Menominee County Community Mental Health Clinic

in Michigan. During his tenure in the rural upper-peninsula of Michigan, Mohatt developed high intensity and high quality community-based programming for persons with developmental disabilities and mental illnesses. These programs, ranging from ICF/MR services to Assertive Community Treatment (ACT) teams, were developed through the utilization of the same funds formerly expended exclusively for institutional care. In the 18 months prior to participating in the ACT program, a sample group of 32 persons with severe and persistent mental illness used over 3,000 days of inpatient services at an average cost of \$400 per day. In the 18 months following their enrollment in the ACT program, this same group used fewer than 300 days of inpatient care. The daily cost of ACT was \$100 per person, a system savings of approximately \$300 per person per day. The saved funds were then available to expand services for other area residents.

#### **John A. Morris**

John Morris served an interim appointment as Director of Mental Health for South Carolina from 1995 to 1997; he also served as Deputy State Director. Before 1990, he held numerous clinical and administrative positions in the Department of Mental Health, having begun his career as a ward attendant at the South Carolina State Hospital in 1969 and become a program director for the Missouri Department of Mental Health in the mid-1970's.

Morris currently holds a dual appointment as Professor of Neuropsychiatry and Behavioral Sciences at the University of South Carolina (USC) School of Medicine, and Director of Interdisciplinary Studies in the South Carolina Department of Mental Health's Division of Education, Training and Research. He is a member of the Affiliate Faculty of the Institute for Families in Society at USC and Adjunct Professor in the USC School of Social Work, where he lectures on health and mental health policy. Principal Investigator on a federally funded grant to build consensus for the statewide replication of a rural assertive community treatment model, he also serves as Project Co-Director and Moderator of TeleConsultations, an interactive teleconference series on mental health issues that is broadcast statewide. A frequent guest lecturer in both university settings and at state and national meetings,

he is the author or co-author of a number of journal articles and book chapters on mental health policy issues.

#### **Charles Moseley, Ed.D.**

For 11 years, Charles Moseley was the Director of the Vermont Division of Developmental Services, where he led the efforts to close the state's institution, transition all services to individuals with developmental disabilities to individualized community based alternatives, and more recently, to restructure the service delivery system to institute principles of managed care and self-directed services. He holds a doctorate in special education, mental retardation policy, from Syracuse University and has consulted with several states and organizations on the development of community services for people diagnosed as having mental retardation or developmental disabilities. Moseley is the Co-Director of the Robert Wood Johnson Foundation's Self Determination Project and the Associate Director of the Institute on Disability at the University of New Hampshire.

#### **Frank M. Ochberg, M.D.**

Frank Ochberg was Director of the Michigan Department of Mental Health from 1979 to 1981. Prior to serving in that position, he spent seven years at the National Institute of Mental Health (NIMH), the last two as Associate Director. He has published over 100 titles, many on community mental health services, in scientific and lay publications and has served as a consultant to the Federal Bureau of Investigation, the U.S. Secret Service, and the London Metropolitan Police (Scotland Yard). At Michigan State University, he is a Clinical Professor of Psychiatry, an Adjunct Professor of Criminal Justice, and an Adjunct Professor of Journalism. Ochberg is a psychiatrist in private practice in Michigan.

#### **Robert L. Okin, MD**

Robert Okin is the former Commissioner of Mental Health for both the state of Vermont and the state of Massachusetts. He is a consultant with Mental Disabilities Rights International and is a

nationally and internationally known expert on human rights for people with mental disabilities.

As Chief of Service of the San Francisco General Hospital (SFGH) Department of Psychiatry, Professor of Clinical Psychiatry, and Vice Chair of the University of California at San Francisco (UCSF) School of Medicine's Department of Psychiatry, Okin's major role is to provide leadership to and administration of the SFGH site of the UCSF Department of Psychiatry. Since he joined the Department in 1990, his major effort has been focused in the development and expansion of both mental health/substance abuse services and the academic mission at this site. He has overseen the development of crucial services for San Francisco's most critically mentally ill, including the SFGH Department of Psychiatry's Case Management Program for High Users of the Emergency Department which received this year's National Association of Public Hospital's Safety Net Award, the Crisis Resolution Team for psychiatric patients in crisis, a Partial Hospitalization Program for patients transitioning from acute inpatient care, a variety of outpatient and inpatient Substance Abuse Programs, the establishment of the Division of Psychosocial Medicine, and the Department of Public Health's capitate contract for comprehensive mental health services for 200 of San Francisco's most expensive users of the mental health system.

#### **Mike Pedneau**

As the North Carolina State Director of Mental Health, Developmental Disabilities and Substance Abuse, Mike Pedneau brought federal class action lawsuits to closure by complying with the settlement agreement in *Willie M. v. Hunt* and by achieving compliance in the Court Order in *Thomas S. v. Hunt*. The latter case involved a class of 2,000 people with mental retardation who spent more than 30 days in state psychiatric hospitals. By treating and habilitating people with mental retardation in community settings, North Carolina was able to continue downsizing its state hospitals and shift nearly 60% of the cost of this care to federal Medicaid funds. Since compliance, North Carolina has continued to divert people with mental retardation from care in state hospitals unless extreme circumstances are involved. During Pedneau's



six years as the State Director, the federal mental retardation/developmental disabilities waiver was expanded and slots under the waiver were expanded dramatically in exchange for decreasing the state's institutional beds by 4% per year.

#### **Peter P. Polloni**

Peter Polloni was Executive Director of the Pennsylvania Arc from 1971 to 1977, a time of great change for persons with developmental disabilities as the trend shifted from institutional care to community integration. After the Arc, he served for two years as the director of the Pennsylvania Office of Mental Retardation before becoming the Deputy Director for the Ohio Department of Mental Retardation/Developmental Disabilities. In northeast Ohio, he oversaw the downsizing of two institutions and the enlargement of community alternatives. Polloni left state government to spend 14 years with Mentor, a company that has been a leader in the development of community-based services for persons with severe disabilities.

#### **R. Emmett Poundstone, III**

Emmett Poundstone served as Commissioner of the Alabama Department of Mental Health and Mental Retardation on two separate occasions, from 1985 to 1986 and from 1995 to 1996. In addition to serving as Commissioner, he has held several other positions within the Alabama Department of Mental Health and Mental Retardation during his nearly 23 years of employment. Positions held include Chief Council from 1979 to 1981, Director of the Division of Legal and Administrative Services from 1981 to 1984 and Associate Commissioner for Mental Illness from 1988 to 1995. He retired in 1997 as the Deputy Commissioner.

#### **Toni Richardson**

Toni Richardson served as Commissioner of the Connecticut Department of Mental Retardation from January 1990 to January 1995, a period marked by the development of community-based alternatives to replace institutional facilities and an emphasis on

the development of high quality community services. During part of that time, Richardson served on the Board of Directors of the National Association of State Developmental Disability Directors.

#### **Thomas D. Romeo**

Thomas Romeo was Director of Rhode Island's statewide agency for mental health for 12 years. With the support of four Governors, the Rhode Island State Legislature, and many citizens, he established a system of services based upon individual needs and ultimate return to one's home community. In Rhode Island, institutional settings continue to be considered a "last resort."

#### **Kingsley R. Ross**

Kingsley Ross served as Florida's Assistant Secretary for Developmental Services from 1987 to 1992. During his tenure, he directed a statewide agency with over 5,000 employees and a budget in excess of \$500 million; approved policy, plans, budgets, and procedures; proposed and lobbied for legislation; advised and consulted local, state, and federal officials as well as constituency groups. Ross' accomplishments included the following: creating and implementing an integrated organization-wide fiscal and customer information system, linking budgets and expenditures to consumer demand for services for person with developmental disabilities; increasing revenues by \$16.5 million in 6-month period; creating and implementing fee-based cost reimbursement systems; developing systems for evaluating the service quality at the national, regional, and individual consumer level; providing national and international consultation to a variety of private and public organizations serving persons with developmental disabilities on topics ranging from contract negotiations to management and budget control systems. From 1983 to 1987, Ross was Executive Director of the Florida chapter of the Arc. He currently works as the President of Minuteman Systems, Inc.

### **Lyn Rucker**

Lyn Rucker has over 25 years experience in the planning, development, administration, quality enhancement, and financing of institutional and community support systems for people with a variety of needs in the United States and, for the past 12 years, in the United Kingdom as well. She has extensive experience in the evaluation and review of developmental disabilities and mental health supports and services, in-patient psychiatric hospitals, natural supports and community services, and services offered in forensic units. From 1987 to 1991, Rucker oversaw the Division of Developmental Disabilities for the state of Arizona. In that position, she was responsible for designing and directing the first managed care system for people with developmental disabilities in the United States. Ninety-six percent of the children and adults receiving health, medical, and individualized supports and services did so in the community. During her four years as state director in Arizona, the state closed an institution in Phoenix and downsized by half their facility in Tucson. One private ICF/MR was also closed.

### **Jerry L. Schrader, M.D.**

Jerry Schrader was the Director of Mental Health and Developmental Disabilities for the State of Alaska from 1973 to 1978. The following two years he spent as the Chief of Planning and Technical Assistance in the Bay Area Regional Office of the Department of Mental Health of the State of California. As the Chief, Schrader was the second highest ranking official in the regional office, representing the Department in providing state approval and oversight to the five counties surrounding San Francisco Bay. Schrader is a Fellow of the American Psychiatric Association.

### **Walter W. Shervington, M.D.**

From 1992 to 1996, Walter Shervington served as the Assistant Secretary of the Office of Mental Health, the mental health authority for the state of Louisiana. Among his duties were the operations of six state-run psychiatric hospitals, including a foren-

sic hospital, and 46 state-run community mental health centers or clinics; innovating, developing, and monitoring new services as the needs demand; and overseeing the expenditure of more than \$20 million in federal grant funds. Prior to his appointment as Assistant Secretary, Shervington was an Associate Professor of Psychiatry with tenure at the Louisiana State University School of Medicine. Early in his career, he spent four years as Chief of the Psychiatry Training Branch of the National Institutes of Mental Health. Shervington is a member of the U.S. Department of Health and Human Services, Health Resources and Services Administration, National HIV/AIDS Advisory Committee and is a psychiatrist in private practice.

### **Edward Russell Skarnulis, Ph.D.**

From 1985 to 1990, Edward Skarnulis served as the Director of Minnesota's Division for Persons with Developmental Disabilities. Prior to his tenure in Minnesota, he managed statewide programs in Texas and Kentucky. In 1990, Skarnulis was appointed as one of three members of a review panel created under the terms of a consent decree in *Homeward Bound v. Hissom Memorial Center*, in the United States District Court for the Northern District of Oklahoma. The panel worked with staff to oversee the court-ordered closing of an 850-bed state institution for person with mental retardation. Skarnulis is a member of the National Advisory Board of the Research and Training Center on Community Integration at Syracuse University and a consulting editor for *Mental Retardation*, the journal of the American Association on Mental Retardation.

### **Thomas Sullivan**

Thomas Sullivan has worked in state government for 32 years in three different states: Connecticut, Florida and, most recently, Tennessee where he served as State Director for the past two and a half years until resigning at the end of January. Sullivan entered the field in 1967 as a direct care worker in a state facility in Connecticut, launching a career that would involve a number of "hands on" and administrative positions in facilities and commu-



nity programs. For the past 21 years, all of his experience has been in community-based services. Sullivan has been involved, along with a number of other people, in the closing of three residential facilities: the Mansfield Training School and Seaside Regional Center in Connecticut and Nat. T. Winston Developmental Center in Tennessee.

#### **Richard C. Surles**

Richard Surles has more than two decades of experience in health planning and programming. Previously, he was a commissioner of mental health for the states of New York and Vermont, an administrator for the Office of Mental Health and Mental Retardation for the City and County of Philadelphia, an assistant director of the North Carolina Division of Mental Health and Mental Retardation, and a member of the Mental Health Study Commission for the North Carolina State Legislature. Surles also was vice president for national operations and Chief Executive Officer of Public Sector Services at Merit Behavioral Care.

In addition, Surles has taught and held positions as co-director of the Post-Doctoral Program in Mental Health Evaluation at the School of Public Health and associate director for the Developmental Disabilities Technical Assistance System at the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill. He has served on numerous national advisory committees on mental health and health care policy, and has published more than 30 articles in industry journals. He is as an honorary fellow of the American Psychiatric Association and has received several career recognition awards from the National Alliance for the Mentally Ill, the National Mental Health Association and the National Association of State Mental Health Directors.

#### **Henry Tomes, Ph.D.**

From 1989 to 1991, Henry Tomes was the Commissioner of Mental Health for the state of Massachusetts, after having served as deputy commissioner for several years. In both positions, he expanded community mental health programs, by increasing placements of persons with mental illness in community resi-

dences, providing for significant expansion of psychosocial rehabilitation programs, and beginning the process of closing and/or downsizing the Commonwealth's mental health hospitals. Tomes is currently employed as Executive Director, Public Interest, American Psychological Association from 1991. His Public Interest Directorate supports policy and administrative activities associated with issues involving gender, age, sexual orientation, disabilities, ethnic minorities, AIDS and urban affairs.

#### **Harold M. Visotsky, M.D.**

Harold Visotsky's career in mental health has spanned more than 40 years. After four years as Director of Mental Health for Chicago, Visotsky served six years as Director of the Illinois state mental health system. Visotsky has accumulated numerous awards for his work in the U.S. and abroad, including the Presidential Award for Contributions to Hospital Psychiatry by the American Association of General Hospital Psychiatrists and two Gold Medals for Contributions to the Field of Psychiatry from the American College of Psychiatrists. He has provided consultation on mental health care to the governments of Japan, Italy, and the former U.S.S.R. and was Chair of a U.S. State Department/National Institute of Mental Health Team on an official visit to investigate possible human rights violations in psychiatric hospitals of the former U.S.S.R.

Visotsky is the Owen L. Coon Professor of the Department of Psychiatry and Behavioral Sciences at Northwestern University Medical School. He also serves as a Senior Consultant to the Center for Mental Health and Psychiatry Services of the American Hospital Association, an organization he directed from 1979 to 1985.

#### **Gary K. Weeks**

##### **Director, Oregon Department of Human Resources**

Gary Weeks is the current Director of the Oregon Department of Human Resources, the state's health and human services agency. In addition to overseeing the Mental Health and Developmental Disability Services Division, Weeks directs the work of

the Adult and Family Services Division, Health Division, Senior and Disabled Services Division, State Office for Services to Children and Families, Vocational Rehabilitation Division, Office of Alcohol and Drug Abuse Programs, and the Office of Medical Assistance Programs (Medicaid). The department has a staff of 9,650 and a 1997-99 biennial budget of \$6 billion. Weeks is signing on in his official capacity.

#### **Ric Zaharia, Ph.D., FAAMR**

Ric Zaharia served as Director of the Utah Division of Services to People with Disabilities from 1990-1995. During his tenure, deinstitutionalization processes were established to implement state statutes requiring services in the least restrictive environment. Utah's Home and Community Based Services waiver and state budgeting processes were revised to expand community capacity and permit the routine movement of institutional monies behind individuals for whom treatment teams recommended community placement. During this period, approximately 150 of the 450 residents of the state's one institution were successfully moved into community settings. In addition, diversion efforts were established to redirect unnecessary institutional admissions to community placements. These efforts continue today.

Zaharia has also been involved in efforts in Colorado and North Carolina to accomplish the same state policies relative to placement in the least restrictive, most integrated settings. In Colorado as the DD Division's Director of Behavioral Services, he directed the implementation of supports to relocate approximately 100 individuals with dual diagnoses out of the Colorado State Hospital and Wheat Ridge Regional Center. In North Carolina as a facility director, he devised institutional funding transfers to support the movement of approximately 400 people out of the Caswell Center and into more appropriate community settings based on the recommendations of treatment teams.

#### **George A. Zitnay, Ph.D.**

While Assistant Commissioner for Mental Retardation for Massachusetts, George Zitnay managed the administration of a

comprehensive statewide service delivery system for persons with mental retardation, autism, and traumatic brain injury. He left state government to become Executive Director of the Joseph P. Kennedy, Jr. Foundation, where his accomplishments included directing special projects on ethics and training of mental retardation professionals and teaching at Georgetown University.

From 1990 to 1998, Zitnay served as President of the Brain Injury Association. He directed all activities of the Association, including training, research and prevention in brain injury. He has served on the National Institutes of Health Advisory Board for the National Institute on Child Health and Human Development, as Chair of the National Center on Medical Rehabilitation, and as Chair of the National Institute on Disability and Rehabilitation Research. Zitnay presently is a Professor and Director of Research and Training at the Virginia Neurological Institute, University of Virginia; Clinical Director of the John Jane Brain Injury Center; and President of the International Brain Injury Association.